
EDITORIAL

As *Public Health Reports* enters its 121st year, we begin a bold adventure. Co-sponsorship by the Association of Schools of Public Health (ASPH) now enables us to exploit the most efficient and effective aspects of commercial publishing while remaining the journal of the US Public Health Service. On May 1, 1997, the Public Health Service and the Association of Schools of Public Health signed an agreement to co-sponsor *Public Health Reports*. Now ASPH has engaged Oxford University Press to help fulfill its obligations under the co-sponsorship agreement. This issue of *Public Health Reports* has been printed and distributed for ASPH by the Press, a nonprofit entity with its US journal operations located in Cary, North Carolina.

A few of our readers will have already purchased a subscription from Oxford; for those of you who subscribed in the past, your next renewal form will come from Oxford. The price, although higher, remains among the very lowest of journal subscription prices. ASPH will continue to provide *Public Health Reports*, free of charge, to the Depository Library Program of the Superintendent of Documents.

Why did we make this change? Operating in an era of constrained Federal budgets and under rules that prohibit the Public Health Service from recouping any portion of subscription revenue to support the journal, we saw no other way to expand circulation and improve our product. Working for ASPH, Oxford will produce, distribute, and market *Public Health Reports*. ASPH and Oxford will share revenues from subscription and advertising sales and from new products derived from *Public Health Reports* articles. Income received by ASPH will be used exclusively to improve the journal. In this way we expect to pay for electronic access to the journal on the World Wide Web and vastly improved service to our subscribers.

We would like to thank all who have made this groundbreaking change possible—the US Congress's Joint Committee on Printing, which approved the co-sponsorship approach; the Government Printing Office, itself in the midst of rapid change, which sadly wished us well; the Assistant Secretary for Health and the Public Health Service agencies, who encouraged this departure from standard government publishing practice; the Office of General Counsel, which worked tirelessly on the details of draft agreement after draft agreement; and ASPH, without whom this "great leap forward" would not have been possible. ■

A PERSONAL FAREWELL

I must abandon the editorial "we" to send a personal farewell to all of our readers, reviewers, contributors, and the hundreds of others who have helped us reinvent *Public Health Reports* over the last four years. I have accepted a new chair in public health at Tufts Medical School, and I am leaving the editorship of *Public Health Reports*.

I was rewarded at the start by strong support from Philip R. Lee, Jo Ivey Boufford, and Martis Davis. As I leave, David Satcher, Nicole Lurie, and Damon Thompson have adopted their strong belief that *Public Health Reports* must survive and prosper. I believe that the alliance between the agencies of the US Public Health Service and the Association of Schools of Public Health is unbeatable and that *Public Health Reports* has a bright future.

Thank you for your help.

Anthony Robbins, MD ■

LETTERS

Vaccine Coverage

Like Bolton et al. [Nov/Dec 1998; 113:521-6, 527-32], we analyzed vaccination data derived from parental recall, vaccination cards, and medical records. However, the purpose of our study was not to determine the impact on vaccination coverage estimates of various sources of vaccination data, but rather to determine the usefulness of parental recall or parent-held vaccination cards in identifying undervaccinated children. We used data from the 1994 National Health Interview Survey (NHIS)¹ and the 1994 National Immunization Provider Record Check Study,² a nationally representative survey of children ages 19–35 months.

We calculated vaccination status for receipt of: four or more doses of DTP/DT; three or more doses of poliovirus vaccine; three or more doses of Hib; at least one dose of MMR; and the vaccine combination including all of the above (the 4:3:1:3 series). We determined the sensitivity, specificity, positive predictive value, and negative predictive value of household-based reports of vaccination status using provider reports of vaccination status as the "gold standard" or true vaccination status. For example, the sensitivity of the vaccination card is the proportion of children in need of vaccination according to provider records who are identified as such by the vaccination card. The specificity of the vaccination card is the proportion of children not in need of vaccination who are correctly identified as such by the vaccination card.

Of the 2651 children ages 19 through 35 months in the NHIS sample, immunization questionnaires were completed for 2439 children (92%). We analyzed data for the 1762 children for whom both use-